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ABSTRACT

Mental health workers may be assaulted by their violent patients. A study was conducted to examine one predictor variable of aggressive behavior in patients. It was hypothesized that authoritarian traits in the mental health worker could result in more assaults against the mental health worker by patients. Participants (N=32) were mental health workers in a crisis intervention unit of a hospital in Miami, Florida. The workers included 3 psychiatrists, 16 nurses, 3 social workers, and 10 mental health technicians. A questionnaire was administered to determine the number of patient assaults against respondents and to collect demographic information on the respondents. Participants' personality traits were assessed using the F scale measure of authoritarianism (Adorno, 1950). The results indicated that men were attacked more than 16 times as often as women. Sixty-eight percent of the workers reported attacks, and 58 percent of those workers felt that the attacks could have been prevented. The relationship between authoritarianism and attack, though positive, was not significant. Further research about attitudes likely to provoke violence, prevention of patient assaults, and qualifications of workers is recommended. (ABL)

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IS THE AUTHORITARIAN TRAIT IN MENTAL HEALTH WORKERS A SIGNIFICANT PREDICTOR VARIABLE OF PATIENT ASSAULT?

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STATEMENT OF THE PROBLEM

"All staff who accept employment in a mental health facility accept an obligation to control violence . . . The organization supports all staff control of violent behavior which is carried out in accord with accepted procedures."[1]

Accepted procedures consist of helping the patient identify the anxiety prompting his angry behavior, and to reassure him that he will not be allowed to lose control. The next step is to call a STAT team. The team generally consists of five large muscular males, who by their very presence, are a show of force. "Generally five members of the staff are sufficient to restrain an average-sized patient. One person should attempt to distract the patient while others take extremities, with one person to each limb."[2] The STAT team carries the patient, face down, to a quiet area, and the nurse gives the patient a parenteral sedative.

The situation is particularly troublesome to mental health staff who find that they are seeing an increasing number of potentially violent and destructive patients. "Reason for the increase of such patients include the dwindling services

in state hospitals, the inability of traditional correctional facilities to rehabilitate or contain the criminally violent, the reluctance of private therapists to treat threatening difficult patients"[3] and the recent influx of refugees with violent histories.

"This concern and the need to handle violent patients has traditionally and more or less explicitly been the reason for using large muscular male nursing aids on the staffs of psychiatric hospitals."[4]

Ms. Remo, Risk-Control Supervisor of the Crisis Unit at Jackson Memorial Hospital in Miami, remarked, "the only way to control violence is to replace the five foot two, one hundred pound female staff member with six foot one, two hundred pound males."[5]

Madden, Lion, and Penna surveyed by questionnaire, 115 psychiatrists who held full or part-time clinical appointments at The University of Maryland, School of Medicine. Each psychiatrist was asked "whether or not he had in the course of his career been assaulted."[6] Of the 115 psychiatrists sampled, sixty-eight reported having been assaulted. The finding that almost sixty percent of the clinicians surveyed reported having been assaulted is interesting and surprising. It is surprising because, "the majority of psychiatrists are attracted

to psychiatry, on at least a theoretical level, because of its contemplative nature and its use of verbal skills, rather than physical management as the primary tool for treating patients."[7] This is in contrast to other medical specialties in which physical handling of patients is more prevalent.

Whitman, Armao and Dent mailed a questionnaire to 184 mental health workers in the three professions of psychiatry, psychology and social work in the Cincinnati, Ohio area. The questionnaire required the mental health workers to report the number of patients seen in one calendar year and to note the number of times assaulted.

> The overall data indicate that in one calendar year, one of every eleven patients, (615 of 6,720) seen in a variety of psychotherapy settings presented an assaultive threat to others in the environment. One hundred twenty-six were physically threatening to the psychotherapist, and forty-two actually engaged in assaultive behavior toward the therapist.[8]

A major finding of this study thus emerged as a ratio: Patients who presented threats to others, those presenting threats to the therapist and those who had been assaulted (15: 3:1).

"In a recent survey of 100 psychiatrists, psychologists and social workers working in a metropolitan area, twenty-four percent reported being assaulted by one or more patients during a one-year period."[9]

Skodol, Toksoz and Karasu surveyed 367 patients who presented themselves to a psychiatric emergency room in Bronx,

New York. Of the 367 patients, sixty-two patients, or seventeen percent, were deemed violent because of "outwardly directed aggressive ideation or behavior in their clinical presentations."[10]

B. Ekblom was able to review the literature on acts of violence by psychiatric patients from 1889 to 1970 in two and one-half pages, which suggests the literature is sparse. Ekblom cited only one study by Kolle which suggested that staff attitudes might provoke violence.[11]

Since this time some research has been done in this area.

In 1976, Levy and Hartocollis studied the incidence of violence in a psychiatric unit organized as a therapeutic community whose nursing staff was composed entirely of women. They compared this unit with another, staffed according to the traditional male and female nursing patterns. In one year, the unit comprised of women had no incidents of violence, but the traditionally staffed unit had thirteen violent incidents. The authors hypothesized that "the expectation of violence among psychiatric patients and the consequent use of large male nursing aids to control violence, may represent a self-fulfilling prophecy."[12]

Anthony L. Guenther theorized "mental hospital violence may be productively interpreted as a complex form of interaction

between two or more participants, as a physiological response to perceived structural constraints, as an intricate cost-benefit assessment, and as a maladaption to special arrangements in the living environment.[13]

The issue of violence is a critical and timely one. There are as many unanswered questions and possible factors that might contribute to violence. Nurses need to know what provokes violence. Is the five foot two, one hundred pound female nurse a greater assault risk or lesser assault risk because she is a female?

The present research effort seeks to examine a predictor variable of aggressive behavior in patients.

LITERATURE REVIEW

VIOLENCE IN MENTAL HEALTH SETTINGS

Levy and Harticollis hypothesized that women are assaulted less because violence-prone patients may find female staff less provocative than male staff and that, conversely, when confronted with threatening patients, in absence of male staff, "female staff may be more apt to rely on non-aggressive manners and feminine intuition rather than resort to reactive, police-like methods, which are typical of masculine behavior and values in our culture."[14]

Spiegel pointed out that "when a male aid is used as an instrument of confrontation, the probability of violence becomes greatly enhanced because the male aides formal or informal role as a masculine authority is based on the intent to do violence. The intent is potentiated by female nursing personnel who expect the male aide to confront troublesome patients for them.[15]

Edelman describes a community mental health clinic (CMHC) in Boston Massachusetts. Staff and clients of a CMHC share a milieu that is distinct from other areas where

explosions of violence may occur. "In a CMHC, the physical plant is generally unsuited and ill-equipped for dealing with violence, the role expectations and outcome are less predictable, and the adequacy of the manpower and support systems is unclear."[16] Into such an environment comes an imminently violent patient. He is restless, he paces. Perhaps he is muttering expletives to himself or has a strange look in his eyes. His fists and facial muscles are tense. There is an unmistakable tension that fills the room. The first staff member the patient encounters is the receptionist. Edelman states,it is fortunate that most receptionists are women, because an initial interaction with a woman seems to have a calming effect on the patient. . . "He may draw comfort from the unconscious and conscious awareness that his internal turmoil and precarious control may be stabilized by external calm and structures."[17] Edelman also believes that it is less threatening to the patient if a woman therapist conducts the interview. "She should acknowledge the patient's state of agitation by saying she knows it must be very unpleasant fo: him and she wants to work with him to ease his distress and prevent him from losing control. . . The patient must be given every opportunity to ventilate his anger verbally."[18]

Madden, Lean and Penna, in their research, questioned whether or not psychiatrists might provoke the violent behavior

by their patients. Fifty-five percent of the psychiatrists assaulted reported that they could have anticipated the assault, and fifty-three percent felt they had acted in a provocative manner."[19]

> Some therapists felt the incidence of violence would not have occurred if they had backed off. Several therapists reported candidly that they did not particularly like the patient who assaulted them and might have projected this feeling to the patient. One senior psychiatrist felt that therapists might act in a seductive manner, project an unconscious expectation that an assault will take place, or attempt to veil an underlying hostility with kindness, all of which can lead to assaultive behavior on the part of the patient. Other clinicians stated they thought the following triggered assaults: refusing to meet a patient's requests, forcing a patient to take medications, setting too many limits, transference reactions, homosexual panic and the material being dealt with in therapy.[20]

Anders states the therapist must help the patient identify the anxiety promoting the patient's angry behaviors and reassure him that he will not lose control. "A potentially violent patient generally senses when he is about to lose control and he seeks reassurance that his behavior will be contained."[21]

Talking states Penningroth "is the single most effective way to help a patient gain self-control and should be used increasingly in violent situations."[22]

Menninger notes when a patient hints he may lose control, it is difficult for the therapist to assess the degree of

threat, communicate, and at the same time experience reduction of his own anxiety. This takes much insight, flexibility and skill.[23]

Harticollis concludes, psychiatric patients can frustrate us and offend us to the extent they can threaten us, but the threat comes so much from inside ourselves as it does from the patients. It is often anger and anxiety that makes psychiatric patients look so threatening. Instead, we need to reflect with the patients about the nature of their anger, anxiety and fear and to realize, we like them, harbor similar feelings which handicap our understanding and tend to reinforce the patient's negative transference which evokes violence.[24]

Authoritarian Personality

Scodel and Mussen studied authoritarian and non-authoritarian individuals in their study "Social Perceptions of Authoritarian and Nonauthoritarians" based on the California Study of the Authoritarian personality. Authoritarian and non-authoritarian populations were selected from a group of 276 students in an introductory psychology course at Ohio State University who had responded to a questionnaire which was presented as a survey of students' findings about themselves and important topics. Actually, the questionnaire consisted of a randomly ordered presentation of twenty-eight items from

the F scale, and is designed to measure authoritarianism. The results concluded that authoritarian personalities are "rigid, extraceptive, repressed, conforming, stereotypical in their thinking and intolerant of ambiguity;" whereas nonauthoritarian individuals have been described as flexible, intraceptive, and having greater capacity for intense interpersonal relationships."[25] On the basis of the descriptions of the authoritarian and nonauthoritarian personalities certain predictions about behavior were established.

> Thus, it would seem that the authoritarian individual would not be keenly aware of the emotional and social attitudes of others with whom he has brief and casual contact . . . His approach to others is conventional, non-personalized, and essentially lacking in insight. . . The non-authoritarian personality, on the other hand, has less need to perceive similarity between his own and others' values and attitudes. His reactions to others will be more highly individualized and his evaluations more objective. Therefore, he will be better equipped to use subtle personality cues and make more personalized insightful assessments of the attitudes and values of others.[26]

Meer administered the F scale to seventy-one male and female undergraduate students at Western Reserve University, who were divided into high (authoritarian) and low (non-authoritarian) groups based on their scores from the F scale. Meer observed the relationship between authoritarian attitudes and dreams. The study indicated persons with high F scores (authoritarians) "had more aggression in dreams with characters classified as strangers, . . . than with characters classified

as family and friends. . . For lows there was no difference in aggression and in friendliness with strangers, friends or family.[27]

Camilleri administered the F scale to 156 students present at a regular meeting of an introductory anthropology course at The University of California, Los Angeles, in the spring of 1952. The class was chosen because it was attended by students of both sexes from many departments. Results indicated that individuals who scored high on the F scale, had "an externalized super-ego, a weak ego, and a general tendency to project outward his own unacceptable feelings and impulses,"[28] especially onto minority groups.

Thibaut and Rieken studied the authoritarian personality and the communication of aggression. They observed "authoritarian individuals because of their greater sensitivity to the power dimension of a relationship, would be more likely than low authoritarians to attach importance to status in evaluating another person. . ."[29]

Sheppard, Pintryn, et al. used the Emotions Profile Index and a modified form of the Opinion Scale in evaluating seventy-seven psychiatric attendants staffing a large state mental hospital. Results from the study indicated that "persons who have an authoritarian trait possess attitudes which reflect the belief that mentally ill persons comprise an inferior class of people requiring coercive handling. . ."[30]

In sum, the literature suggests it is important as therapists to recognize that we harbor similar feelings to the violent patients. Assessment and communication are necessary tools in preventing violence.

Authoritarian individuals as compared with non-authoritarian individuals have less interpersonal skills, view mentally ill persons as inferior, have more aggressive tendencies toward strangers who they see as minorities, and are more likely to project their own unacceptable feelings outward.

THEORETICAL FRAMEWORK

In recent years, investigators have generated various hypothesis as to what makes a patient react violently.

"Violence is a response to feelings of impotence--helplessness in the face of a perceived threat. Admission to a mental health facility tends to confirm a patient's worst fears about himself--that he is losing control of his behavior, and this is accompanied by a marked increase in anxiety."[31] Patients perceiving threats from within or from without, respond with fight or flight responses. In most mental health facilities, the chances of flight are rare. Usually a patient can flee only as far as his room. Fighting as well as fleeing are both viewed as uncooperative responses which warrant action.

Anxiety and fear are common emotions to the patient in a mental health facility. Guntrip hypothesized that aggression is generated by fear and it is often anger and anxiety that compels people to take action in fight or flight.[33]

Reynolds states "violence must be seen as part of a global emergency response system built deeply into the vertebrate nervous system. The organism's perception of an emergency leads to an appropriate but non-specific arousal state including vascular, endocrine and neurophysiological responses, all designated to guarantee readiness for some kind of quick and effective action."[34]

Seyle in 1956 developed a theory of adaption to stress. "The theory postulates that a person's body responds to the nonspecific demands of stress by means of the General Adaption Syndrome. Stress may be internal or external to the individual and is manifested by the syndrome which consists of non-specifically induced changes occurring within the person's body.[35]

Seyle's theory is based on the premise that in the stressed state, "humans seek to attain a desired state (e.g., the reduction of stress) by mobilizing the body's general defense mechanisms to overact in order to maintain life."[36]

The General Adaption Syndrome consists of three phases; the alarm phase, the phase of adaption, and the phase of exhaustion.

> During the alarm phase frustrating situations produce a heightened state of arousal manifested as aggression(flight),or flight (withdrawal from the situation) or diffuse increased anxiety. The sympathetic nervous system responds physiologically to the alarm by: increased heart rate, difficult or rapid breathing, frequent yawning, dry mouth, chest pains, anorexia, nausea, vomiting, abdominal cramps, diarrhea, gas pains, butterflies, flushing, excessive perspiration, cold sweats, shifts in body temperature, urgency and frequent urination, dysmenorrhea, frigidity, impotence, aching muscles and joints, anthralgia, arthritis, backache, headache, wryneck, an increase in blood pressure, blood transfer from the gastrointestinal tract to the muscles, liver release of sugar adrenal production of epinephrine, reduced peristallic activity and dilution of pupils.[37]

During the resistance stage "physiologic functions are at abnormal levels for prolonged periods in an attempt to defend the body against stress."[38] In an attempt to decrease anxiety, the thought process becomes distorted. In the final process, the stage of exhaustion, resources are overused or have failed.[39]

If a person feels anxious, fearful and threatened, the body and mind become physiologically and psychologically prepared to fight or flee.

Authoritarian personalities, because of their attitudes and beliefs toward mentally ill patients, i.e., the need for coercive handling, will more likely be an object of an aggressive act.

STATEMENT OF PURPOSE

The purpose of this study is to test the following hypothesis:

"There is a significant relationship between the authoritarian trait in a mental health staff member and the number of patient assaults against the staff member."

Definition of Terms

1. Aggression - the practice of making attacks on mental health workers.

2. Anxiety - "vague feelings of alarm that persons report when faced with a stressful situation."[39]

3. Authoritarian - 1) referring to a characteristic ideological orientation; 2) a complex of personality attributes which appear to be related to such an ideology; 3) relatively high score on the F scale.

4. Crisis Unit - twenty-four hour/day emergency psychiatric facility.

5. F Scale - a Likert-type scale which measures the authoritarian personality trait.

6. Mental Health Worker - Any staff member employed to work directly with psychiatric patients.

7. Non Authoritarian Personality - 1) referring to a characteristic ideological orientation; 2) a complex of personality attributes which appear to be related to such an ideology; 3) relatively low score on the F scale.

8. Potentially Dangerous Individual -

One who actually inflicted or attempted to inflict serious injury on another person; 2) harbors anger, hostility and resentment; 3) enjoys witnessing or inflicting suffering; 4) lacks altruistic and compassionate concern for others; 5) sees himself as a victim rather than aggressor; 6) resents or rejects authority; 7) is primarily concerned with his own discomfort; 8) is intolerant of frustration or delay of satisfaction; 9) lacks control of his own impulses;

10) has immature attitudes toward social responsibility;

11) lacks insight into his own psychological structure;

12) distorts perception of reality. . .[41]

9. Significance Reliability - .05 level of significance.

10. Violence - (see aggression).

PLAN FOR DATA COLLECTION

The research approach is ex post facto. It attempts to determine if authoritarianism, an independent variable, has resulted in the occurrence of aggression, the dependent variable. The experimenter did not control the independent variable. Therefore, the ex post facto design was appropriate to the purpose of the study.

The target population consisted of all thirty-two employees at The Crisis Intervention Unit in Jackson Memorial Hospital in Miami. The mental health workers consist of: Psychiatrists: one medical director in charge of the Crisis unit, two first year psychiatric residents. Psychiatrists are responsible for medical and social histories and prescribing medications. Psychiatrists may commit a patient to the hospital. Nurses: Three registered nurses that head the unit and allocate responsibility and thirteen registered nurses who work under the head nurses. Registered nurses are responsible for assisting the physician, providing patient care, taking vital signs, administering medications and assessment of the patients via psychosocial histories. Three social workers who gather data

regarding fee for services and provide information for placement. Ten mental health technicians who assist the registered nurse by taking vital signs, providing patient care, assessing the patient by way of a psychosocial history and acting as a member of the STAT team.

Two instruments have been used. One was a questionnaire that attempted to determine the number of patient assaults inflicted on mental health workers. Other variables looked at included profession, age, sex, race, ethnic group, level of education, length of time worked at Jackson Memorial Hospital Crisis Unit, belief that attack could have been prevented, and fear of being attacked by a psychiatric patient.

The staff's self-report was a valid measure, as the investigater assumed the staff would be truthful in their answers. The assault questionnaire was divided into two parts--those who have been assaulted and those who have not.

The second instrument used was the F scale. The scale was designed by T.W. Adorno in 1950 "as a covert measure at the personality level of incipient fascistic tendencies, although it is now commonly interpreted as a measure of authoritarianism."[42]

The questions on the F scale fall into the following categories:

Authoritarian submission--submissive, uncritical attitude toward idealized moral authorities of the ingroup. (Questions 1,3,5,12,14,27,29,38,41 and 44.)

Authoritarian aggression--tendency to be on the lookout for, and to condemn, reject, and punish people who violate conventional values. (Questions, 7,8,11,15,17,22,24,25, 38.)

Conventionalism--rigid adherence to conventional, middle-class values. (Questions 1,7,24,26,35,36,42.)

Anti-intraception--opposition to the subjective, the imaginative, the tender-minded. (Questions 6,20,24,26,40, 42.)

Superstition and stereotypy--the belief in mystical determinants of the individual's fate, the disposition to think in rigid categories. (Questions 3,5,9,16,18,21,34,44.)

Power and toughness--preoccupation with the dominance-submission, strong-weak, leader-follower dimension, identification with power figures, overemphasis upon the conventionalized attributes of the ego, exaggerated assertion of strength and toughness. (Questions 2,8,11,13,14,16,32,33.).

Destructiveness and cyncism--generalized hostility, vilification of the human. (Questions 4,28,19,33,39,43,30.)

Projectivity--the disposition to believe that wild and dangerous things go on in the world, the projection outward

of unconscious emotional impulses. (Questions 10, 20, 21, 23, 30, 32.)

Sex-exaggerated concern with sexual goings on. (Questions 15,23,25,42.)[43]

The data that was collected was quantified for analysis by the individual categories previously cited, and the scale as a whole. The F scale consists of forty-five items and is a Likert-type scale. Subjects were asked to strongly agree (+6), agree somewhat (+5), slightly agree (4), disagree slightly (+3), disagree somewhat (+2), and disagree strongly (+1). No neutral or undecided option was allowed, but omission of an item was scored as an average of all responses on that particular section of the F scale.

Subjects were divided into two groups, high authoritarian and low authoritarian for each category and on all categories combined.

"The average of the reliability coefficients is .90, their range is .81 to .97 . . . A reliability of .90 may be interpreted to mean that the scale can place individuals along a dimension, in this case a broad and complex dimension with a small margin of error."[44] "The test shows internal consistencies, split half reliabilities for given response categories were as high as .88-95."[45]

The F scale is suggested to be a valid predictor of certain behaviors such as dogmatism, misanthropy, xenophobia, suggestibility and acquiescence.

Dogmatism - Analysis of the F scale by Robeach led to the influence that authoritarianism as measured by the F scale was a reflection in the personal-social relations area of a more generalized personality trait of dogmatism.

Robeach was able to construct a Dogmatic Personality Scale composed of statements concerning overidentification will cause guilt and ego centrism which correlated .67 with the F scale.[46]

Misanthropy - Defined by Sullivan and Adelson refer to derogatory statements about ethnic minorities and assenting to derogatory statements about people in general. The correlation with the F scale is a .43.[47]

Xenophobia - Campbell and McCandless developed a measure of xenophobia which appears to be free from potential acquiescence bias. "The instrument measured reactions to several minority groups on several dimensions, such as morality and social distance. The correlation with the F scale was found to be high."[48]

Suggestibility - "Gula and Getzels submitted nineteen inner directed and nineteen outer directed slogans which were

associated with opposing behavioral tendencies to a group of subjects. The subjects who tended to accept any type of slogan correlated significantly with scores on the F scale.[49]

Acquiescence - "Cohn found a correlation of .41 between the F scale and the tendency to respond yes to MMPI items. This simplied that acquiescence, the tendency to concur with any statement, could account for some of the variance of the F scale."[50]

The F scale is "one of the most frequently used instruments in the area of personality and attitude measurement,"[51] it does however have its limitations.

A feature of the F scale that has come under recent critical scrutiny is the unilateral wording of the items. These are so phrased that agreement with them is scored as indicative of potential fascism, or authoritarianism, disagreement as non-fascistic or non-authoritarianism. Most of the criticism stems from Crombach's summary of earlier work on response set and his indication of its importance is answering test or scale items. Some subjects, it appears, have general tendencies to accept or reject items. According to Crombach, response set is more likely to occur when a given item is vague or otherwise lacking in specificity or is in an area with which the individual is unfamiliar. Such considerations are pertinent to many of the

items on the F scale which are characterized by non-specificity of referent."[52]

Kuscht and Dellehay state there are "methodological problems bequeathed in the F scale because of the many shortcomings in the original research."[53]

Using the F scale in a survey design has in practice an additional drawback. "Typically, very short forms of the test are used (e.g., five item versions), which cannot be evaluated the same as the original form(s) of the F scale."[54]

"In experimental work done with the F scale, authoritarianism is almost never an independent variable, nor is it a true dependent variable, because typically, subjects are selected by extreme scores without random assignment or matching subjects."[55]

PROCEDURE FOR DATA COLLECTION

The researcher administered the two questionnaires to all mental health workers at The Crisis Intervention Unit at Jackson Memorial Hospital in Miami, Florida. One questionnaire examined if the staff worker had ever been assaulted, and the number of times assaulted. The second questionnaire designed by T.W. Adorno measured facism and the authoritarianism trait.

The Crisis Intervention Unit is located on the first floor of Jackson Memorial Mental Health Institute and is open twenty-four hours each day, seven days a week. Its primary purpose is to observe, assess, treat, and evaluate all psychiatric emergencies, regardless of ability to pay for services. Patients are voluntary or involuntary, and are brought to the Crisis Unit by self, friends, or family, private psychiatrist or the police.

The Crisis Unit can hold up to twenty patients, but will usually not hold a patient longer than a few days. After holding a patient, the facility either sends the patient home, admits him/her to the inpatient unit at Jackson Memorial

Hospital, another inpatient unit, an outpatient facility at a correctional institute, depending on the patient's condition, treatment, diagnosis and prognosis.

Of the thirty-two employees at the crisis unit, three psychiatrists (one medical director and two residents), sixteen registered nurses (three head nurses and thirteen staff registered nurses), three social workers and ten mental health technicians that received the questionnaires one day, twenty-five returned the questionnaire the following day. (One psychiatric resident, one head nurse, eleven staff registered nurses, two social workers, and ten mental health technicians.)

The two-part tests were attached. In one-half of the tests, the assault questionnaire was first; in the second half, the F scale was on top. They were randomly assigned to mental health workers at the crisis unit.

The Pearson product moment correlation r lends itself to this study as it has unearthed any linear relationship that exists between the Variables on the F scale, the complete F scale, and the number of patient assaults.

The multivariate analysis of variance (Manova) detects cause and effect between Staff member assaults and the F scale.

Protection of human rights was assured by way of a cover letter (Appendix A).

Assumptions underlying the study are that authoritarianism is a stable and measurable trait and the F scale reliably taps this trait. It is not assumed that authoritarianism is a randomly distributed variable.

The limitations in the study are the scale itself, as it was designed in 1950, just five years after World War II, and the limitations previously cited. Additional limitations include the ex post facto nature of the study.

The variable authoritarianism, by its nature, cannot be manipulated by the experimenter, therefore, any of the other variables, known or unknown, that covary with authoritarianism, could account for differences in the frequency of being the object of violence, i.e., educational levels of the staff, authoritative positions, etc.

Another limitation is the specific nature of the Crisis Intervention Unit which may or may not generalize to other crisis units.

The present political ziegeit in Miami may have an influence on mental health worker attitudes toward authority groups. In addition, because of the recent influx of violent refugees to Miami, the jails have been overcrowded and many antisocial violent persons are admitted to the Crisis Unit with the intent to do harm.

A possible limitation is the idea that authoritarian persons may be more likely to confront a potentially violent patient than a nonauthoritarian person. Therefore, the incidence of being attacked increases because their encounters with the potentially violent person is higher. Authoritarian personalities may not define an assault in the same manner in which nonauthoritarian persons define the term.

PLAN FOR DATA ANALYSIS

The assault questionnaire was broken down according to age, sex, race, ethnic group, level of education, length of time worked at the Crisis Unit, number of times attacked, belief attack could have been prevented, and fear of being attacked by a patient. The mean for each variable was computed and the range was reported. The Median and mode were reported when it varied significantly from the mean.

To measure the strength of any linear relationship, the Pearson product-moment correlation r was computed on the nine variables of the F scale and number of attacks on the assault questionnaire. A high score on each variable of the F scale reflected a high level of authoritarianism. The correlation coefficient was considered significant if it reached a probability level of .05 (one out of 5) or .01 (one out of one hundred).

A second type of analysis used was the multivariate analysis of variance. This was used to detect which variables or subscales on the F scale had a causation effect as to whether or not high scores indicated an increased number of

attacks. In addition, it determined the direction of causation, i.e., does a high score on the entire F scale cause staff members to be a target of attack.

Tables are used to facilitate interpretation of the data (See Tables 1, 2, 2A, 3, and 4).

INTERPRETATION OF DATA

Twenty-five questionnaires were returned--fourteen were males and eleven were females.

The assault questionnaire yielded the following results (see Table 1).

Ages of respondents ranged from twenty-three years to forty-three years. The average age was twenty-seven years.

Two mental health workers were black, one mental health worker was Hispanic, and twenty-two were white. All were American citizens.

The level of education ranges from two years of college to nine years of college. The average years in college was four years.

The length of time the mental health workers have worked at Crisis have a range from two days to three years. The average is thirteen months.

The number of attacks inflicted on staff members by patients ranged from zero to one hundred. The average was ten and one-half, the median and mode were one. The average number of attacks on women were .9, on males 18.2. This is significant at the level $p < .05$.

TABLE 1

MEAN BREAKDOWN OF VARIABLES ON ASSAULT QUESTIONNAIRE FOR MALES AND FEMALES

VARIABLES	FEMALE $\bar{X}$	MALE $\bar{X}$	TOTAL $\bar{X}$
Age	28 years	26.6 years	27 years
Level of Education	4 years	4 years	4 years
Time worked at Crisis	11 months	15.7 months	13 months
Number of times assaulted	.9 times	18.2 times	10.5 times
Brief assault could have been prevented	2	8	10
Fear of being attacked	4	8	12.5

Seventeen out of twenty-five staff members were assaulted at least once. Twelve were males and five were females. Ten of the seventeen that were assaulted felt the incident could have been prevented, seven felt it could not. Eight males out of the twelve attacked, felt the incident could have been prevented, two of the five females attacked felt the assault could have been stopped.

Twelve out of twenty-five staff workers reported they were afraid of being hurt by a patient on the job; thirteen stated they had no such fears. Of the twelve that stated they feared being assaulted, eight were males and four were females. There was not any significant correlation established between having been assaulted and being afraid.

The F scale was broken down into the nine individual scales that comprise the total scale. The Pearson product moment correlation r yielded a significant positive relationship at the $p < .01$ level ($p = .388$) between number of assaults and authoritarian submission and power and toughness. It yielded a significant positive relationship at the $p < .05$ level ($p = .496$) between number of assaults and authoritarian aggression, conventionalism, superstition and stereotypy and power and toughness (See Table 2A).

TABLE 2

PEARSON PRODUCT MOMENT CORRELATION r

Variable	Number of Attacks	Authoritarian Submission	Authoritarian Aggression	Conventionalism	Intra	Superstition Stereotypy	Power	Destr	Proj	Sex
Authoritarian Submission	0.641 **	13.071								
Authoritarian Aggression	0.488 *	0.771	11.159							
Conventionalism	0.486 *	0.771	0.907							
Anti Intraception	0.371	0.685	0.889	0.864	7.831					
Superstition & Stereotypy	0.449 *	0.713	0.587	0.601	0.517	10.054				
Power & Toughness	0.507 **	0.774	0.907	0.870	0.864	0.627	9.760			
Destructiveness & Cynicism	0.242	0.685	0.809	0.782	0.743	0.529	0.803	8.766		
Projectivity	0.329	0.716	0.801	0.771	0.810	0.686	0.816	0.888	7.939	
Sex	0.278	0.644	0.933	0.859	0.913	0.558	0.839	0.790	0.806	5.035

$p < .01$ = 388 ** = .01

$p < .05$ = 996 * = .05

TABLE 2A

SUMMARY OF SIGNIFICANT

DATA OF TABLE 2

VARIABLE	NUMBER OF ATTACKS
Authoritarian Submission	0.641 **
Authoritarian Aggression	0.488 *
Conventionalism	0.486 *
Superstition and Stereotypy	0.449 *
Power and Destructiveness	0.507 **

** = .01

* = .05

$p < .05$ .388

$p < .01$ .496

The Multivariate Analysis of variance for the nine scales showed a significant causation effect at the $p < .01$ level for authoritarian submission and superstition and stereotypy at the $p < .05$ level (See Tables 3 & 4).

The complete F scale, using the Multivariates yielded a positive relationship between number of attacks and a high score and the F scale ($p < .296$), however, the correlation is not significant.

TABLE 3

MULTIVARIATE ANALYSIS OF VARIANCE USING WILKS LAMBDA CRITERION

Variables	Attacked		Never Attacked		F Ratio
	$\bar{X}$	50	$\bar{X}$	50	
**Authoritarian Submission	38.333	11.545	22.428	9.658	10.377
Authoritarian Aggression	24.555	11.937	18.857	8.194	1.332
Conventionalism	21.444	8.140	15.571	7.742	2.690
Anti Intraception	18.388	8.037	14.142	6.866	1.513
*Superstition & Stereotypy	26.388	9.387	16.142	8.153	6.414
Power & Toughness	25.388	9.603	18.428	9.071	2.511
Destructiveness & Cynicism	22.000	9.042	16.571	7.138	2.014
Projectivity	19.833	7.445	14.285	8.320	2.627
Sex	10.833	5.260	8.714	4.386	0.999

**p = < .01

*p = < .05

TABLE 4

MULTIVARIATE ANALYSIS OF VARIANCE

Variable	F Ratio	Mean SQ	P less than	1
Authoritarian Submission	10.377	1274.923	0.003**	1.394
Authoritarian Aggression	1.332	163.658	0.260	-2.019
Conventionalism	2.690	173.840	0.114	0.290
Anti Intraception	1.513	90.864	0.231	0.210
Superstition & Stereotypy	6.414	529.104	0.018*	0.331
Power & Toughness	2.511	225.068	0.126	0.163
Destructiveness & Cynicism	2.014	148.525	0.169	0.285
Projectivity	2.627	155.111	0.118	-0.336
Sex	0.888	22.631	0.3555	0.469

*p = < .05

**p = < .01

TABLE 5

MULTIVARIATE TESTS OF
SIGNIFICANCE OF
COMPLETE F SCALE

Variables Combined	F Ratio	p less than
	1.338	0.296

DISCUSSION AND CONCLUSION

The issue of violence is critical and timely. Mental health workers report there is an increasing number of assaultive patients seen in the psychiatric setting. The concern and the need to control the violent patient has resulted in the use of large muscular males who are a show of force merely by their presence.

The literature on violence by psychiatric patients is sparse, and only one study by Kolle suggested that staff attitudes might provoke violence.

Levy and Hartocollis in 1976 studied psychiatric units composed of the standard male and female pattern and compared it with units staffed with only women. Their findings showed that in one year, the traditionally staffed unit had thirteen violent incidents, and the ward comprised of women had no incidents of violence. The authors hypothesized that women are attacked less because they are more apt to rely on non-aggressive manners. Despite this research, psychiatric wards continue to staff units with large muscular males. In fact, the risk control department at the Crisis Intervention Unit

at Jackson Memorial Hospital in Miami, is looking to replace their small women staff members with large males as a means to control violence.

Authoritarian individuals tend to be more aggressive than non-authoritarians. Authoritarian individuals also tend to rely less on verbal communication and project their own unacceptable feelings outward. This is particularly troublesome as authoritarians view mentally ill persons as inferior.[57]

Investigators that have studied the issue of violence have hypothesized that in the face of a perceived threat, people will fight or flight.

Are authoritarian individuals more threatening than non-authoritarians? The present research effort asked: "Is the authoritarian trait in mental health workers a significant predictor variable of patient assault?"

Two instruments were used to determine if a relationship between being attacked correlated with having an authoritarian personality. One instrument was an assault questionnaire that asked mental health workers if they were ever attacked and to describe the incident (See Appendix B). The second instrument was the F scale designed by Adorno in 1950 which reliably taps the authoritarian trait (See Appendix C).

Of the thirty-two employees at the Crisis Unit in Jackson Memorial Hospital, twenty-five were used as subjects

in this study, as they returned their questionnaires: (One psychiatrist, twelve registered nurses, two social workers, and ten mental health technicians). Responses were coded by number and the results were confidential.

A breakdown of the assault questionnaire supported Levy and Hartocollis' findings. Men were attacked 16.38 times more than women. This is significant at the $p < .05$ level.

The investigator recommends that the risk control department at Jackson study these findings before replacing small females with large muscular males.

Seventeen out of the twenty-five staff members used in the study were attacked at least once. The fact that sixty-eight percent of the employees in a psychiatric setting have been assaulted by patients, is horrifying.

Fifty-eight percent of those assaulted felt the incident could have been prevented. These findings are consistent with the research performed by Madden, Lion, and Penna. Forty-eight percent of all twenty-five employees feared being attacked by patients. Further research is needed to assess how fear of being attacked is correlated with patient care.

The Multivariate Analysis of Variance showed a positive relationship between authoritarianism and being attacked. The correlation, however, is not significant. This is possibly

due to the limitations of the scale itself (designed in 1950), and the types of questioned asked (i.e., relevant for the time, but are presently outdated). Another limitation of this study was the *small population size N = 25.* Perhaps a larger sample would yield significant results. Other possible limitations include those previously cited in the study.

The F scale was also analyzed according to the nine individual scales that comprise the total scale. The Pearson r showed a significant correlation between number of attacks and five of the nine sub-scales--(authoritarian submission, authoritarian aggression, conventionalism, superstition and stereotypy, and power and toughness). The investigator hypothesizes that these five scales reflect more timely issues and suggests further work be done to assess if this hypothesis is correct.

The Multivariate Analysis of Variance shows a significant cause and effect relationship between being attacked and the belief that others should submit to aurhorities. Perhaps authoritarian submissive individuals believe they are the authorities.

It is not surprising that those individuals that believe in fate and are rigid are assaulted more since many potentially violent situations warrant flexibility.

The investigater urges further research be done in this area. What attitudes provoke violence? What can prevent patient assault? Who is most qualified to work with psychiatric patients?

"All staff who accept employment in a mental health facility accept an obligation to control violence. . . ."

Nurses work in mental health facilities and should research what controls violence.

APPENDIX A

Covered Letter

The purpose of these questionnaires is to assess certain attitudes of mental health workers.

You will be asked to answer a series of questions. There are no right or wrong answers, answer the way you feel or think.

Although there are no risks and no direct benefits that can be guaranteed from your participation, hopefully the results of the study will help nurses to better assist and support patients in the mental health facility.

Your responses will be coded by number, rather than by your name, thus the results are entirely confidential.

Your participation is entirely voluntary. You may withdraw from participation at any time if you feel you wish to do so.

The study has received the approval of the appropriate review board of the University of Miami.

Investigator: Donna Sofian, R.N.
652-8493

APPENDIX B

Assault Questionnaire

1. Name
2. Age
3. Sex
4. Race
5. Ethnic group
6. Level of education
7. How long have you worked at the Crisis Unit at Jackson Memorial Hospital?
8. Have you ever been assaulted by a patient in the Crisis Unit?
9. If so, how many times?

   Briefly describe the assault.
10. Do you feel the incident could have been prevented?

    Briefly describe the precipitating events.
11. Are you afraid of being assaulted on the job by a patient?
12. Have you been assaulted on other jobs in a psychiatric setting?

APPENDIX C

The Questions on the F Scale Consist of

1. Obedience and respect for authority are the most important virtues children should learn.

2. No weakness or difficulty can hold us back if we have enough will power.

3. Science has its place, but there are many important things that can never possibly be understood by the human mind.

4. Human nature being what it is, there will always be war and conflict.

5. Every person should have complete faith in some supernatural power whose decisions he obeys without question.

6. When a person has a problem or worry, it is best for him not to think about it, but to keep busy with more cheerful things.

7. A person who has bad manners, habits, and breeding, can hardly expect to get along with decent people.

8. What the youth needs most is strict discipline, rugged determination, and the will to work for family and country.

9. Some people are born with an urge to jump from high places.

10. Nowadays when so many different kinds of people move around and mix together so much, a person has to protect himself against catching an infection or disease from them.

11. An insult to honor should always be punished.

12. Young people sometimes get rebellious ideas, but as they grow up they ought to get over them and settle down.

13. It is best to use some prewar authorities in Germany to keep order and prevent chaos.

14. What a country needs most, more than laws and political programs, is a few courageous, tireless, devoted leaders in whom the people can put their faith.

15. Sex crimes, such as rap e and attacks on children, deserve more than mere imprisonment, such criminals ought to be publicly whipped, or worse.

16. People can be divided into two distinct classes: the weak and the strong.

17. There is hardly anything lower than a person who does not feel a great love, gratitude, and respect for his parents.

18. Some day it will probably be shown that astrology can explain a lot of things.

19. The true American way of life is disappearing so fast that force may be necessary to preserve it.

20. Nowadays more and more people are prying into matters that should remain personal and private.

21. Wars and social troubles may someday be ended by an earthquake or flood that will destroy the whole world.

22. Most of our social problems would be solved if we could somehow get rid of the immoral, crooked and feebleminded people.

23. The wild sex life of the Old Greeks and Romans was tame compared to some of the goings on in this country, even in places where people might least expect it.

24. If people would talk less and work more, everybody would be better off.

25. Homosexuals are hardly better than criminals and ought to be severely punished.

26. The businessman and the manufacturer are much more important to society than the artist and professor.

27. No sane, normal, decent person could ever think of hurting a close friend or relative.

28. Familiarity breeds contempt.

29. Nobody ever learned anything really important except through suffering.

30. After a war, we may expect a crime wave of gangsters and ruffians.

31. It's a mistake to trust anybody who doesn't look you straight in the eye.

32. Most people don't realize how much our lives are controlled by plots hatched in secret by politicians.

33. Too many people today are living in an unnatural, soft way; we should return to the fundamentals, to a more red-blooded active way of life.

34. It is more than a remarkable coincidence that Japan had an earthquake on Pearl Harbor Day, December 7, 1944.

35. The modern church, with its many rules and hypotheses does not appeal to the deeply religious person; it appeals mainly to the childish, the insecure, and the uncritical.

36. One should avoid doing things in public which appear wrong to others, even though one knows that those things are really right.

37. One of the main values of progressive education is that it gives the child great freedom in expressing those natural impulses and desires so often frowned upon by conventional middle-class society.

38. He is indeed, contemptible who does not feel an undying love, gratitude and respect for his parents.

39. Today everything is unstable; we should be prepared for a period of constant change, conflict and upheaval.

40. Novels or stories that tell about what people think and feel are more interesting than those which contain mainly action, romance and adventure.

41. It is essential for learning or effective work that our teachers or bosses outline in detail what is to be done and exactly how to go about it.

42. There is too much emphasis in college on intellectual and theoretical topics, not enough emphasis on practical matters and virtues of living.

43. No matter how they act on the surface, men are interested in women for only one reason.

44. Science like chemistry, physics and medicine have carried man very far, but there are many important things that can never possibly be understood by the human mind.

45. No sane, normal, decent person could ever think of hurting a close friend or relative.[56]

TITLE

Is the Authoritarian Trait in Mental Health Workers a Significant Predictor Variable of Patient Assault?

FOOTNOTES

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[4]Pauline Levy and Peter Hartocollis, "Nursing Aids and Patient Violence," American Journal of Psychiatry, April 1976, p. 429.

[5]Interview with Donna Remo, R.N., Risk Control Management of the Crisis Unit at Jackson Memorial Hospital, Miami, Florida, 14 February 1981.

[6]Denis Madden, et al., "Assault on Psychiatrists by Patients," American Journal of Psychiatry, 133:4 April 1976, p. 422.

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